REPORT OF THE TOBACCO AND SMOKING CESSATION TASK FORCE TO THE SUSTINET BOARD

July 1, 2010

I. Summary

The Tobacco and Smoking Cessation Task Force is pleased to present this report to the Sustinet Board and to the Joint Standing Committee of the Legislature. This report describes the work of the Task Force over the past eight months and represents the thoughtful contributions of representatives from health care, public health, retail organizations and provider groups.

The Task Force found that although Connecticut has experienced a reduction in smoking rates over the past decade, the effects of tobacco use significantly contribute to the growing total health care costs. In reviewing the available research and the initiatives of other states in this area, the Task Force firmly believes that the rate of tobacco use should and can continue to decline.

To achieve this continued decline, the Task Force has developed a series of recommendations that address the needs of individuals attempting to quit smoking; preventing young people from becoming smokers; opportunities to increase resources dedicated to this problem; and enhanced measurement strategies to improve understanding of tobacco users and how to help them. Key recommendations include expanding access to nicotine replacement items and supportive quit counseling; supporting smoking bans in homes, in and around schools, and other child-friendly areas; update and support the state's Tobacco Use Prevention and Control Plan; determine whether changes in pricing should be pursued; and allow sales of nicotine replacement gum and patches as over the counter medications.

II. Purpose and Mission of this Task Force

A. Charge to the Task Force

The Sustinet Legislation created the Tobacco and Smoking Cessation Task Force to examine evidence-based strategies for preventing and reducing tobacco use by children and adults, and then develop a comprehensive plan that will effectuate a reduction in tobacco use by children and adults.

B. Members of the Task Force

Andrew Salner
Director
Helen & Harry Gray Cancer Center
Hartford Hospital
Task Force Co-Chair

Jeannette DeJesus
President and CEO
Hispanic Health Council
Task Force Co-Chair

Kevin Lembo
Healthcare Advocate
Office of the Healthcare Advocate
Board of Directors Liaison

Nancy Wyman
Comptroller
Office of the Comptroller
State of Connecticut
Board of Directors Liaison

David Gregorio
Professor
Associate Chair for Education
Director, Graduate Program in Public Health
Community Medicine & Health Care
University of Connecticut Health Center

Barbara Koren
Retail Marketing Manager
Mercury Fuel

Frank Scifo
Director of Primary Care Development
St Vincent's Medical Center

David Scribner
Representative
House of Representatives
State of Connecticut House Republican Office Legislative

Task Force Members wish to thank the Workgroup members who have supported the Task Force's work and who were instrumental in the writing and editing of this Final Report.

Patricia Checko, MATCH Coalition
Robin Cox, Connecticut Department of Mental Health and Addiction Services
Joni Czajkowski, American Heart Association
David Gregorio, UConn School of Medicine
Bryte Johnson, American Cancer Society
Richard Kehoe, Office of the Connecticut Attorneys General
Barbara Koren, Mercury Fuel
Dawn Mays-Hardy, American Lung Association
Kevin O'Flaherty, Campaign for Tobacco free Kids
Barbara Walsh, Connecticut DPH

C. Methodology

The Tobacco Task Force created two workgroups which subsequently merged to focus on data collection and on program elements of tobacco cessation. The Task Force met monthly to discuss the subcommittees' findings and to hear in-depth presentations about key issues.

III. The Task Force's Approach

The Sustinet Tobacco Task Force Co-chairs convened a working group of tobacco experts to review current data and programmatic issues related to tobacco prevention and control and develop recommendation to the Task Force. This report became the basis of the Task Force report to the Sustinet Board of Directors and to the legislature regarding the status of tobacco use as well as prevention and control efforts in the state and recommendations to reduce the burden of tobacco use on the health and healthcare costs of Connecticut residents. The Workgroups were merged into a single group and met from April through June to prepare the recommendations in Section IV.

> ***"Tobacco kills more people each year than losses from WWI, Korea and Vietnam combined, approximately equal to WWII losses."***

The Workgroup relied heavily on reports and guidelines from the Centers for Disease Prevention and Control, data and reports from the Campaign for Tobacco Free Kids, Connecticut Tobacco and Health Trust Fund, and other states' tobacco prevention and control experiences.

The CDC published a document on *Best Practices for Comprehensive Tobacco Control Programs* in August of 1999, shortly after states reached a settlement agreement with the tobacco industry; an updated edition was released in October, 2007.[1] This comprehensive approach includes not only clinical interventions, but also economic, policy, and social strategies aimed at reducing the health and economic consequences of tobacco use. The CDC recommends that state and community interventions, effective health communications, smoking cessation, surveillance and evaluation as well as administration and management should be included in tobacco control programs if they are to be effective.

The *Clinical Practice Guidelines* describe the best treatment for reducing tobacco use and dependence. Originally developed and published in 1996 by

the U.S. Department of Health and Human Services (USDHHS), these *Clinical Practice Guidelines* have been updated three times. The most recent edition, published in 2008, is based upon treatment recommendations from over 8,700 research articles published between 1975 and 2007. These recommendations, addressing both clinical and systems-based interventions, were developed using the best available evidence (also known as evidence-based), and offer guidance to clinicians, as well as administrators of healthcare delivery and insurers. These guidelines view tobacco dependence as a chronic and recurring disease often requiring repeated interventions and multiple quit attempts.[2]

The workgroup supports the findings and recommendations of the recently released Connecticut Public Health Policy Institute Report of April 28, 2010 titled: *Examining Tobacco Use, Consequences and Policies in Connecticut.*[3] The workgroup also recognizes the Massachusetts Department of Public Health and its Massachusetts Tobacco Control Program (MTCP) as a leader in the area of tobacco prevention and control. The workgroup views the MTCP as a model program for its planning approach to comprehensive tobacco control and its many success stories. The MTCP Logic Model is included as an appendix to this document[4] . Finally, the workgroup also reviewed and evaluated the proposed 2020 Healthy People objectives for tobacco use to determine concurrence with the national health objectives.[5]

Recommendations are grouped in four major areas: the burden of tobacco use; Cessation; Prevention; and Policy/Environment Issues. Each section lists the recommendations along with background information and cost/benefit information. Costs or savings related to implementation are provided as available. Also please note that the order of the recommendations does not reflect prioritization or ranking of importance.

A paradox concerning our efforts is that CT is a tobacco producing state.

A. The Burden of Tobacco Use in Connecticut

The Surgeon General reports that tobacco use is the leading preventable cause of disease in the United States. Every year, cigarette smoking is responsible for 1 in 5 of all US deaths (or 443,000); 37% cancer, 32% heart disease and stroke and 21% due to respiratory disease. Smoking accounts for at least 30% of all cancer deaths and 87% of lung cancer deaths.

Chronic diseases are exacerbated by insufficient policies and systems; certain environments in which we live, learn, and work; and limited access to healthcare. The most effective way to improve the health of Connecticut

residents and reduce the burden of chronic diseases is through comprehensive statewide health promotion.

Many deaths resulting from chronic diseases are premature and preventable. In Connecticut, tobacco use continues to be a leading cause of preventable death. Between 2000 and 2004, over 4,800 adults ages 35 and older died each year as a result of tobacco use, a smoking-attributable mortality rate of 238.3/100,000.[6] In addition, another 440 adult nonsmokers die each year from exposure to secondhand smoke.

Annual health care costs in Connecticut attributed to cigarette use are estimated at $2 billion (in 2008 dollars), and the portion of that covered by the State's Medicaid Program is $507 million[3]. In addition, another $1.03 billion of tobacco-related "cost" is attributed to productivity losses of persons affected by tobacco-related diseases/treatments. These amounts do not include the health consequences or economic costs of exposure to secondhand smoke, smoking-related fires, or use of other forms of tobacco.

In 2009, 15.4% of Connecticut's adult population (ages 18+) — over 400,000 individuals — were current cigarette smokers[7]. The prevalence for adult men was 16.2% and for adult women it was 14.7%. The age group with the highest smoking prevalence was among 18 to 24 year-olds (24%). Smoking rates vary by socio-economic status (SES), education, age, race, and presence of psychiatric illness. Overall, smoking rates are higher in individuals with lower income and education levels, in younger adults compared to older adults, military veterans, and in individuals with psychiatric and substance use diagnoses. Nationally, the prevalence of smoking is comparable in Caucasians and African-American groups, but is lower in Hispanics. However in Connecticut smoking rates are higher among Hispanics as compared to Blacks or Whites. For adults who reported an annual income of less than $25,000, the cigarette-smoking rate was 30%, compared to about 12% for those earning $50,000 or more per year.[7]

Health disparity is a hallmark of the tobacco epidemic. While the last ten years have seen dramatic changes in smoking rates for whites, college graduates and persons with incomes over $50,000 per year, these same trends are not true for groups at high risk of being smokers. This is particularly true among Medicaid recipients, persons with no insurance, racial/ethnic groups, persons suffering from mental health and substance abuse, and low socio-economic status. Expanding and developing cessation programs that target these populations and aggressive media

countermarketing activities are needed to reduce tobacco use and smoking-related medical costs.

In 2009, 3.3% of middle school students (3.3% of boys and 3.2% of girls) and 15.3% of high school students (16% of boys and 14.4% of girls) in the state smoked cigarettes.[8] Between 9th and 12th grade smoking prevalence increases from13.9% to 30.1% of all high school students. Data also indicated that 17.3% of middle and 23.5% of high school students who never smoked were susceptible to starting smoking within the next year. This suggests that there is a need for more age-specific programs to prevent smoking initiation.

"**Each day in the United States** -

- *The tobacco industry spends nearly $36 million to market and promote its products*
- *Almost 4,000 adolescents start smoking*
- *Approximately 1,200 current and former smokers die prematurely from tobacco-related diseases*

Data collected from the 2009 Connecticut School Health Survey showed that high school students who smoke are significantly more likely than non-smokers to report poorer mental health. Those with poorer mental health have a higher rate of smoking compared to their peers who report better mental health. Of the high school students who report feeling sad or hopeless in the past 12 months, 27% were smokers, compared to only 13% of the group that did not report those feelings. Among high school students who actually attempted suicide in the past year, 40.9% were smokers, compared to 15.4% of those who did not attempt suicide. These differences are statistically significant.

These findings suggest that students who smoke and students who have depressive disorders could possibly benefit from effective counseling coupled with comprehensive smoking cessation programs. Students who smoke are also more likely to participate in other high risk behaviors than those who do not smoke.[8]

Gathering data and determining effective and evidence-based interventions to decrease smoking prevalence among these populations is crucial.

IV. RECOMMENDATIONS

A. CESSATION: Provide comprehensive tobacco use cessation (TUC) services for all Connecticut Residents

Recommendation #1: Provide Medicaid coverage for tobacco use cessation (TUC) services.

- Effective October 2010, TUC benefits for pregnant women are required under the Federal health care reform.
- Comprehensive TUC benefits should be provided to all Medicaid recipients.
- Connecticut should seek out and secure matching federal funds to help fund this benefit.
- The Department of Social Services should actively promote the benefit with eligible clients.
- Remove the barrier of physician as "gatekeeper" for TUC service
- Expand access to nicotine reduction products (NRTs) to non-prescription retailers licensed to sell other OTC medications. Medicaid offers a formulary for OTCs, such as Claritin, and t should permit vendors to sell and be reimbursed for NRTs.
- Aggressively pursue funding through the $100 million in federal grants (available beginning Jan 2011) for Tobacco Use Cessation Programs targeting Medicaid participants. Develop a plan specifically for Connecticut or in a New England regional approach to secure the needed funds.

Background: Prevalence of smoking among Connecticut adults (≥ 18 years old) is estimated at 15.9%. Medicaid recipients smoke at roughly twice (36%) that level. Medicaid clients (i.e., persons with Low SES, substance addicted persons, the mentally ill and pregnant women) are all at high risk for tobacco addiction. Two variables, in particular, are strongly associated with tobacco use: low education and low income. Smoking prevalence among persons with incomes below $35,000 is 24.4%, whereas prevalence among persons with incomes greater than $35,000 is only 16.5%; the prevalence of smoking among persons with less than high school educations is 29.3%, compared to a prevalence of 11.4% among persons with college degrees.

Pregnant women are an important target population to prevent tobacco use before a subsequent pregnancy, improve birth outcomes, and reduce the effects of secondhand smoke on children. According to the American College of Obstetricians and Gynecologists, smoking is the most modifiable risk factor for poor birth outcomes. Successful treatment of tobacco dependence can achieve a 20% reduction in low birth weight babies, a 17% decrease in preterm births, and an average increase in birth weight of 28 grams. According to the American College of Obstetricians and Gynecologists, a woman is more likely to quit smoking during pregnancy than at any other time in her life.[10] Pregnancy is a good time to intervene with smokers.

In Connecticut, pregnant women on Medicaid (HUSKY A and fee-for-service) were more likely to smoke than all other pregnant mothers giving birth in 2005. Among Medicaid mothers, 15.5% of HUSKYA mothers and 6.5% of fee-for-service mothers smoked, compared to 2.7% of all other mothers who smoked.[11]

A Healthy People 2020 goal is to ensure that evidence-based treatments for smokers are available through state Medicaid programs. The USDHHS 2008 Clinical Prevention Guidelines recommend that evidenced based medication and behavioral smoking cessation treatments should be offered as covered services in public as well as private health insurance plans. That means that smoking cessation coverage should be comprehensive including behavioral counseling and both legend (i.e., drugs requiring a prescription) and over the counter (OTC) drugs.

Connecticut had been at the forefront of tobacco policy when, in the 2002 session, the legislature authorized the coverage of smoking cessation programs for Medicaid recipients. However, the program was never funded, despite a DSS fiscal study prepared at their request in 2006 and a Medicaid reimbursement waiver that would return 62 cents on every dollar spent. Today, Connecticut is one of only four states (Connecticut, Alabama, Georgia and Missouri) still not providing any coverage for tobacco use cessation services for their Medicaid recipients.

In order to expand access to nicotine reduction products (NRTs) Tobacco Task Force recommends granting permission to sell non prescription NRTs. It is also suggested that OTC NRTs be made available in smaller pack sizes vs. the two week supply currently available. The current restrictions on selling non prescription NRTs and the pack size are based on FDA requirements that allow for sale only in pharmacies. Broader access to NRTs in local shopping settings will encourage use among smokers in settings where tobacco sales occur.

Economic Burden: Total health care costs associated with smoking are nearly $2 billion in 2008 dollars. Nearly 35% of Medicaid-insured adults under the age of 65 smokes (compared to just 18.3% of privately-insured adults). The associated health care costs for Medicaid recipients who smoke is more than $507 million in 2008 dollars, costs primarily borne by Connecticut taxpayers.[3]

Program Costs: The following cost estimates assume all individuals will utilize both counseling and NRT or pharmaceutical components. The actual costs may be much less, based on the components the smoker elects to utilize. This cost estimate was developed by the MATCH Coalition as part of the initiative to obtain funding for this benefit during the 2010 legislative session.

Our estimate of tobacco use by Medicaid recipients and benefit of comprehensive cessation interventions assumes that Medicaid recipients ages 19-64 years would be targeted. Currently there are 377,968 Medicaid recipients in this category; we estimate that 173,534 are cigarette smokers. Smoking rates are presumed to be 36%, although estimates ranging from 36-40% have been cited in the literature. Assuming cessation programs are adequately marketed, utilization by 25% of targeted smokers could be anticipated (MassHealth experienced 40% utilization). We further assume all eligible participants would receive an average of 3 counseling session at $150 per session (note: Mass Health experienced much lower utilization of counseling services), and 50% of eligible persons opt to use NRTs and 50% opt for pharmaceuticals. Quit rates are based on use of both counseling and drug therapy (Rates are lower when only counseling is used). The annual estimated reduction in tobacco use by proportion of participants utilizing the benefit is presented in Table 1 below:

Table 1

Estimated Cost for Comprehensive Smoking Cessation for Medicaid Recipients in Connecticut*

	Presumed Utilization Rates	
	25%	**40%**
Clients 19-64 yrs old	173,534	173,534
Percent smokers	36%	36%
Total Smokers	62,472	62,472
Utilization Rate	25%	40%
Program Participants	15,618	24,989
All Receive Counseling	$2,342,709	$3,748,334
90% use NRT	14,056	22,490
50% use NRT & 50% use pharmaceutical	7,028	11,245
NRT cost for 12 wks =$125	$878,516	$1,405,625
25% use Bupropion	3,514	5,623
Bupropion cost for 12 wks =$264	$927,713	$1,484,340
25% use Varenicline	3,514	5,623
Varenicline cost for 12 wks= $475	$1,669,150	$2,670,925
TOTAL COST	**$5,818,088**	**$9,309,225**
# Smokers Quitting = 27.6%	**4,311 fewer smokers per year**	**6,897 fewer smokers per year**

*Based on DSS Medicaid Eligible Recipients for February, 2010, by Age

Health and Cost Benefits: Connecticut lawmakers should look to Massachusetts for a model program that is quickly becoming the standard for the nation. Most evaluation reports deal with long-term savings and health

effects from smoking cessation. In 2006, the Massachusetts legislature enacted a law providing a smoking cessation benefit for all MassHealth (Medicaid) enrollees. The "barrier-free" benefit includes: behavioral counseling, all FDA-approved medication and nicotine replacement, and very low co-pays. In the first 2.5 years of implementation 75,000 MassHealth members used the benefit to try to quit smoking (i.e., 40% of all smokers on MassHealth) and the smoking rate fell 10% a year, from 38.2% to 28.3% (a 26% reduction). Their recent report documented a 38% drop in heart attacks among the cessation benefit users, 17% fewer emergency department visits for asthma symptoms and 17% fewer claims for adverse maternal outcomes.[12] Under the Health Reform Act, all states will be required to provide smoking cessation benefits for pregnant women, effective October 2010. Beginning in January 2011, there will be $100 million in federal grants for TUC programs targeting the Medicaid population.

The American Legacy Foundation estimated that within five years, Connecticut would see annual savings of $91 million (2005 dollars) with a 50 percent decrease in smoking rates, and $18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking.[13]

Recommendation #2: Require all public and private health insurers to provide comprehensive tobacco usage cessation interventions, including counseling and all FDA-approved nicotine replacement therapies and pharmaceuticals.

- Recognize tobacco dependence is a chronic disease for which periodic relapses may be anticipated that require long term use of NRTs and multiple opportunities for quit attempts.
- Recognize relative benefit of multi-modality interventions (e.g., counseling combined with medication) for tobacco use cessation. Best results are achieved with both counseling and medication– (USDHHS Treating Tobacco Use and Dependence: Clinical Practice Guideline, 2008.
- Define and adequately fund through public sources and reimbursement mechanisms, a broad network of clinical and community-based TUC programs and services.
- Make the business case for providing TUC coverage and make workplace programs more affordable and accessible.

Background: About 16% of Connecticut adults (age ≥ 18) smoke, as well as 17% of adolescents (grades 9 through 12). USDHHS Clinical Practice

Guidelines, *Treating Tobacco Use and Dependence: 2008* recommends that evidenced based medication and behavioral smoking cessation treatments should be offered as covered services in public as well as private health insurance plans. That means that smoking cessation coverage should be comprehensive including behavioral counseling and both legend and over the counter (OTC) drugs.

Costs and Benefits There are several business case studies that demonstrate significant cost savings to businesses that went smoke-free and provided smoking cessation benefits to their employees. Total excess cost of a smoking employee to a private employer is $4,279 per year.[14] The Insurance Committee of the Connecticut General Assembly might consider a cost-benefit analysis of the effect of mandatory insurance coverage for comprehensive smoking cessation.

The following recommendations represent three different strategies to provide and integrate cessation services into diverse settings and opportunities.

Recommendation #3: Integrate tobacco use cessation (TUC) interventions into medical encounters.

- Recognize the utility of the 5A's strategy and incorporate the 5A's into all health provider settings: Ask about tobacco use; Advise to quit; Assess willingness to make a quit attempt; Assist the patient in quitting through counseling and medication; and Arrange follow-up.
- All medical questionnaires filled out by patients should include questions on tobacco use, frequency and if the patient would like information on cessation programs.
- Initiate a collaborative service network for referral of patients to aid health care providers in guiding their patients to available programs
- Age, gender, and racial ethnic models for delivering cessation services should be developed, taking into account evidence based treatments. High risk groups should be targeted to decrease disparities through better awareness and access.

- Provide opportunities and support for individuals in traditional and non-traditional health care settings to obtain training in evidence-based TUC protocols.
- Develop and provide training for TUC for traditional and non-traditional providers and develop and fund opportunities and training programs to do so. (Refer to Massachusetts certification program).
- Use the Connecticut Information line 211 to help citizens make connections to local cessation programs.

Background Coordinated tobacco use interventions, delivered in a timely and effective manner, can rapidly reduce the risk of suffering from smoking-related disease. At least 70% of smokers see a physician each year. In addition, 70% of smokers report wanting to quit. Smokers state that a physician's advice to quit is an important motivator for attempting that quit attempt. A brief, three minute assessment and referral process during a routine exam can increase the rate of quitting attempts. Clinicians trained in TUC interventions significantly increase the likelihood of patients' quit attempts.

When appropriate charting (e.g. regular charting of smoking status, use of electronic reminder systems) is used, rates of patients making quit attempts may increase five-fold compared to no intervention.[3] In addition, treatments delivered by multiple types of clinicians are more effective than those delivered by a single type. Even clinician-delivered brief interventions can increase the likelihood of future quit attempts among those not currently looking to quit.

The goal of these strategies is to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified, advised to quit and offered scientifically sound treatments. In addition, treatments delivered by multiple types of clinicians are more effective than those delivered by a single type. In addition, pediatricians and primary health care providers should also screen patients for exposure to second and third-hand smoke.

The sooner a patient quits smoking, the more savings: tobacco dependence treatments cost savings **per life-year** saved is $3,539. Although health care costs may rise during the year the patient is quitting, they decline progressively from that point on. A reimbursement mechanism needs to be established for these types of preventative interventions.

Recommendation #4: Implement and sustain a statewide, telephone Quitline for smoking cessation that provides both counseling and NRT.

Create and sustain funding for the Statewide Tobacco Quit Line at levels that allow it to reach the maximum audience while providing both counseling and NRT services.

Background: There is ample evidence that smoking cessation interventions are effective in reducing the number of individuals who quit smoking. Interventions can be categorized in terms of the type, venue, intensity, duration and cost. They may be behavioral, pharmacological or both. In general, greater intensity of treatment (duration and number of contacts and more modalities of intervention) improves cessation outcomes. Abstinence rates at a minimum of six month follow-up are related to the intensity of the intervention in a dose-response fashion. These range from:

- 5-10% for smokers quitting or their own or with self-help materials
- 10-20% for brief, moderate intensity interventions (counseling only)
- 20- 30+% for maximally intensive individual or combined pharmacological and behavioral interventions

Costs and Benefits: Telephone Quitlines have proven to be an effective smoking cessation intervention. Recognizing their value in helping individuals to stop smoking and acknowledging recommendations for a more robust, countrywide Quitline, DHHS established a national Quitline network in 2004. The network increased funding to states with existing Quitlines, offered grants for the creation of Quitlines in states that did not yet provide the service, and made available smoking cessation counselors in states without Quitlines. The Quitline is a highly useful intervention because advertising the availability of the Quitline helps to stimulate demand and accessing it provides a low-cost service for facilitating cessation. Studies have shown that Quitlines that combine behavioral counseling and medications have significantly higher abstinence rates than medication or counseling alone (28.1%).

Based on the 2006 Connecticut Adult tobacco survey there are 455,850 adults who currently smoke cigarettes in Connecticut. The Department of Public Health has supported a Quitline model in Connecticut for several years using grant funds provided through the Centers for Disease Control to states without their own Quitlines. The Quitline provides free services to callers. These CDC funds are limited and the Quitline contract had provided for telephone

counseling only. (Yr 1, $166,667, Yr 2 $285,000). During those two years there were approximately 1,200 registered callers per year.[10]

In FY 08, Quitline was funded through the Connecticut Cancer Partnership's Comprehensive Cancer Plan's 2006 tobacco allocation and CDC funds for a total of $1.7 million. The new Quitline contract provided for NRT (nicotine patch or gum) and enhanced counseling for persons who registered for the program. Insured enrollees received a two-week starter of NRT. Those without private insurance or on Medicaid received up to eight weeks of NRT. Counseling was provided to all enrollees. The Quitline received over 10,000 calls and enrolled more than 6,000 residents for service in three weeks in July 2007 alone. NRT available through the Quitline was depleted by the end of July, sending nicotine patches to 3,787 callers and nicotine gum to 858 callers. Subsequently, the Quitline provided only enhanced counseling services.[10]

The current cost per Connecticut Quitline user is $497 for uninsured and Medicaid participants and $284 per insured participants. Among the 8,405 registrants who provided insurance information, 46.5% had private insurance, 16.1% had Medicaid coverage, 11.7% had Medicare coverage and 19.3% were uninsured. Although almost half of registrants reported having commercial insurance, most insurance plans do not cover smoking cessation services. From June 2008 through March 2009, the percentage of Medicaid recipients utilizing the Connecticut Quitline increased to 30%.[10]

Women who use tobacco were more likely to utilize the Quitline than men, 62% vs. 38%. One in four Quitline users were 31-50 years old, one-third was 51-60 years old and 14% were 60 or older. Only 12% were 18-30 years old. Eighty percent identified themselves as white, 11% as African-American and 1.5% as other race. By ethnicity 8% identified themselves as Hispanic. Over half of Quitline users (54%) reported an educational level of high school or less.[10]

In a user evaluation conducted among participants who utilized the Quitline between January and June 2007 (prior to the availability of enhanced counseling and NRT), the contractor reported 7- day quit rates of 34%, and 30-day quit rates of 26%. The contractor noted that in a study performed for another state, medication increased quit rates from 33% to 44%.

Using current costs for Quitline services, the Tobacco and Health Trust Fund Board determined that $2 million could reach 11,672 callers and provide a multiple call program to all with a two week starter kit to insured and 8 weeks delivered in 2, 4 week shipments to Uninsured and Medicaid participants. This is a penetration rate of just less than 2% (1.74%) of the adult smoking

population in Connecticut. Increasing this amount to $5 million would increase the penetration rate to about 5% of smokers.[10]

Recommendation #5: Increase the number and types of TUC services available in diverse settings and develop and provide educational opportunities for training traditional and non-traditional TUC service providers.

- Provide adequate training, resources and feedback to ensure that tobacco use cessation providers consistently deliver effective treatments. Offer model training programs on tobacco dependence treatments, and provide continuing education credits and/or other incentives for participation by health care providers. Provide opportunities and support for individuals in traditional and non-traditional health care settings to obtain training in evidence-based protocols. Ensure health care providers have necessary tools to manage a referral system.

- Provide these services in diverse settings, including traditional clinical settings (hospitals, community health centers, school-based health centers, mental health and substance abuse setting) and non-clinical setting, such as local health departments/districts, and social service organizations, as well as the statewide telephone Quitline and website assisted programs.

- Increase the number and type of providers who provide comprehensive cessation services; include pediatricians, psychiatrists, mental health and other health care workers, pharmacists, social workers, health educators and prevention specialists. Initiate a collaborative service network for referral of patients to aid health care providers in guiding their patients to available programs.

- Develop and provide training for both traditional and non-traditional providers (e.g., faith based organizations, Boys/Girls Clubs, Local Health Departments, Continuing education services, etc.) with a standardized, model curriculum and fund opportunities to ensure training attendance.

- Research potential for an online training system for health care providers to break down barriers to training participation.

- Develop age, gender, and racial ethnic models for delivering cessation services that take into account evidence based treatments. Target high risk groups to decrease disparities through better awareness and access.

- Use the Connecticut Information line 211 to help citizens make connections to local cessation programs.

Background: Evidence-based tobacco use cessation methods have been proven to be effective in a variety of populations. Currently TUC cessation services in Connecticut are sparse and under advertised. While programs exist at some Community Health Centers, local health departments/ districts, and hospitals, many are supported by specific grants from the Tobacco and Health Trust Fund, Federal Block Grants or other funding that is not sustainable. Many of these programs will cease when these special funds are gone. There needs to be a mechanism in place, including insurance reimbursement, low cost services and government or privately supported funding, to develop and sustain tobacco use cessation opportunities in diverse settings in the community where people go to seek medical care and social services.

As noted above, even brief encounters with medical providers can increase the rate of quitting. State Quitlines also provide evidence-based cessation services that have been proven effective and need to be sustained.

The Massachusetts Tobacco Control Program has several model programs to reach smokers as well as training programs for providers and tobacco cessation certification. [4] In FY 2009, MTCP continued to provide funding and technical support to 19 community health centers (CHCs) across the state to improve their effectiveness in motivating and assisting patients to quit smoking. The initiative is based on research demonstrating that even brief advice from physicians and nurses can influence patients to make a quit attempt.

MTCP offers confidential information and telephone-based counseling services to help smokers quit through the Massachusetts Smokers' Helpline, which is free to Massachusetts residents. In FY 2009, the Helpline reported receiving 22,000 calls, including those who were referred through QuitWorks and those responding to free nicotine patch promotions. QuitWorks was developed by MTCP in 2002 in collaboration with all major health care insurers in Massachusetts. The QuitWorks fax referral service allows health care providers to connect their patients to free phone counseling services. In FY 2009, health care professionals made nearly 3,500 referrals to the Helpline through QuitWorks. More than one hundred hospitals, community health centers, and DPH programs have adopted the QuitWorks program. Training in smoking cessation counseling is available for providers and others. The University of Massachusetts Medical School provides technical assistance and

training to healthcare providers on smoking cessation and systems change through a contract with MTCP.

The National Tobacco Cessation Collaborative (NTCC) aims to improve the nation's health by increasing successful cessation among tobacco users in all U.S. populations through collaborative efforts and programs. Their website provides information on numerous on-line and in-person training opportunities for smoking cessation training, as well as certification programs for tobacco treatment specialists.[15] NTCC is supported by the nation's leading funders of tobacco control research and advocacy: the American Cancer Society, American Legacy Foundation, Centers for Disease Control and Prevention, National Cancer Institute, National Institute on Drug Abuse and Robert Wood Johnson Foundation.

The Connecticut Certification Board, a state body that currently certifies Alcohol and Drug counselors is having discussions related to creating a Tobacco Treatment Specialist certification.[16]

Cost/Benefit Analysis: The effectiveness of TUC is well documented. Increasing the places where TUC is available and the number of persons who can provide it will vastly increase the potential for smokers to quit. Combining this training with systems changes increases the rate of attempts for tobacco use cessation. Any reduction in smoking has a lifetime of savings, and tobacco dependence treatment can prevent the development of even more costly chronic diseases.

Recommendation #6: Make the business case for smoking cessation benefits for employees.

Background: Cigarette smoking is highly prevalent in the United States, and the adverse effects of cigarette smoking have a heavy impact on employers. Employers assume the costs of health care, disability, and lost work time for employees who smoke. Due to the cost-burden of smoking on employers, providing smoking cessation benefit coverage for employees can be extremely valuable.

For businesses, making an investment in tobacco cessation benefits not only improves employee health but also reduces the significant direct and indirect costs associated with tobacco use. In fact, paying for tobacco use treatment is regarded as the single most cost-effective health insurance benefit for adults and it is also considered the benefit with the most positive impact on health.[17]

Literature has demonstrated that smoking among employees can have a significant cost impact on employers with respect to lost productivity and increased health care costs.

- The CDC estimates that the average smoker costs an employer $3400 per year in smoking-attributed lost productivity and direct medical costs. However, reports show that only 4% of employers provide a comprehensive program.
- A 2007 study by Halpern and colleagues analyzed the impact of smoking cessation benefits on workplace costs and employee quit rates.[18]
- Smoking cessation benefit coverage yielded a greater number of successful quit attempts and a decreased rate of smoking-related diseases. Cost savings (reduced health care and workplace costs) over 4 years exceeded the cost of the smoking cessation benefit

Blue Cross and Blue Shield of Minnesota and Kaiser Permanente Northwest have each developed models for calculating the Return On Investment of tobacco cessation services.

Cost-Benefit Analysis: Scotts Miracle-Gro Company is a model for smoke-free workplaces tied to smoking cessation benefits. It is the world's largest marketer of branded consumer products for lawn and garden care, with a workforce of 6,000 employees and $2.9 billion in annual sales. The company's CEO cited the rising cost of healthcare coverage and the desire to have a healthy workforce as reasons for a tobacco-free workplace policy. The employer was willing to provide all cessation assistance necessary to provide assistance necessary for the employee to break their nicotine addiction[14]

B. PREVENTION: Reduce the health and economic burden of tobacco use by:

- Preventing young people from starting to smoke
- Helping current smokers to quit
- Protecting children and adults from secondhand smoke
- Identifying and eliminating tobacco-related disparities
- Shaping social norms related to tobacco use.

PREVENTION OF SMOKING INITIATION

Recommendation #7: Require age-appropriate life skill education in grades K-12 in Connecticut that address anti-tobacco education, drug and alcohol use prevention, nutrition, stress management and exercise.

- Incorporate life skill education within existing science, mathematics, social studies and language curriculum.
- Emphasize high-risk youth behavior and cultural factors that lead to addictive or unhealthy behavior.
- Initiate a health and wellness curriculum for K-12 students in Connecticut that would incorporate risk factor and behavioral training that is consistent with Sustinet priorities.
- Add no tobacco use to substance-free pledges by student athletes.

PREVENTION OF SECONDHAND SMOKE EXPOSURE: Eliminate the exposure to Secondhand Smoke where people work, live and play

Recommendation #8: Pass legislation that prohibits smoking in all workplaces including restaurants, bars and in public places and eliminate availability of smoking rooms in workplaces. Eliminate small business exemption and smoking room option.

Background: Breathing in secondhand smoke (SHS) is similar to the mainstream smoke inhaled by the smoker in that it is a complex mixture containing many chemicals (including formaldehyde, cyanide, carbon monoxide, ammonia, and nicotine). Many of these are known carcinogens. Exposure to secondhand smoke increases the risk of developing heart disease 25-30% and contributes to between 22,700 and 69,600 premature deaths from heart disease in non-smokers each year. According to the U.S. Surgeon General, eliminating indoor smoking is the only way to fully protect non-smokers from SHS. Connecticut enacted landmark legislation that prohibited smoking in workplaces and public places in 2003 and added bars in 2004. Although the Connecticut law is 100% smoke free in restaurants and bars, the smoking prohibition does not apply to workplaces with fewer than five employees.[3]

The U.S. Small Business Administration (SBA) maintains data for firms by workforce size. In Connecticut, there are approximately 35,000 firms with 1 to 4 employees, or slightly more than 74,000 employees subjected to smoke in the workplace up to 8 hrs. or more every day. 3 Every employee in

Connecticut deserves the right to a smoke-free workplace. As of January 10, 2010, there are 21 states (including Washington, D.C. and Puerto Rico) that have state laws that prohibit smoking in all workplaces, including restaurants and bars, as well as public places.

Connecticut participated in an optional module to the 2008 Behavioral Risk Factor Surveillance System (BRFSS) survey on health conditions and health risk behaviors that accessed SHS exposure at work and in the home as well as home smoking rules. Among Connecticut non-smoking participants, 6.4% reported that they were exposed to SHS inside their indoor workplace. Results of indoor workplace exposure varied widely among states, ranging from 3.2% in Arizona, a state with a 100% smoke free workplace law to 10.6% in West Virginia, a state with no smoke free workplace law. The legislature needs to make Connecticut a 100% smoke free workplace state to protect all our workers from the health effects of SHS.

Health and Cost Benefits: Smoke-free policies have also been found to prompt some smokers to quit smoking. And a number of studies have documented the positive health effects of smoke-free laws. Nine studies have reported that smoke-free laws were associated with rapid, sizeable reductions in hospitalizations for acute myocardial infarct (AMI) or heart attacks. The Pueblo Heart Study examined the impact of a smoke-free ordinance in Pueblo, Colorado. During the 18 months following the implementation of the ordinance, they documented a 27% decrease in the rate of AMI hospitalizations (Phase 1). Over the next 18 months the rate of AMI hospitalizations continued to decrease, with a demonstrated decline of 19% from the post-implementation study and a 41% decline from the pre-implementation period. These findings suggest that smoke-free policies can produce sustained reductions in AMI hospitalizations and that these policies are important in preventing morbidity and mortality associated with heart disease.[3]

Recommendation #9: Ban the sale of E-Cigarettes and other non traditional nicotine delivery devises that are not sanctioned as NRT. Develop a system to review other new products prior to their introduction and acceptance for sale in Connecticut.

- Ban Hookah Bars/Parlors in Connecticut.
- Open Indoor Clean Air Act for review.

Background: Regulation of other nicotine-based products: The tobacco industry is constantly creating and marketing new tobacco-based products.

These include e-cigarettes, Orbs (tobacco containing drops similar to Tic-Tacs), tobacco strips, etc. There is no mechanism in the current Clean Indoor Air Act to regulate or ban these products. There is a need to amend the Connecticut Clean Indoor Air Act to review new products prior to their introduction for sale and ban all non-traditional nicotine delivery systems that are not FDA-approved as nicotine replacement therapies. We cannot rely on the FDA to do so.

Ban Hookah Parlors/Bars in Connecticut: Hookah or water pipe smoking has been practiced for at least 400 years. Hookah is known by a number of names, including narghile, argileh, shisha, hubble-bubble, and goza. Over recent years there has been a resurgence of use, most notably among youth. Small cafes and clubs that rent the use of hookahs and sell special hookah tobacco are making their mark on the young, hip, urban scene and college students. Hookah tobacco is available in a variety of flavors, such as apple mint and cappuccino. Smoking is usually practiced in groups, with the same mouthpiece. Water pipes generally consist of four main parts: the bowl where the tobacco is heated; the base filled with water or other liquids; the pipe that connects the bowl to the base; and the hose and mouthpiece through which smoke is blown.

Even after it has passed through water, the smoke produced by hookah contains high levels of toxic compounds, including carbon monoxide, heavy metals and cancer-causing chemicals. Due to the mode of smoking, hookah smokers may absorb higher concentrations of the toxins found in cigarette smoke. A typical 1-hour smoking session involves inhaling 100-200 times the volume of smoke inhaled with a single cigarette. Hookah smokers are at risk of the same kinds of diseases caused by cigarette smoking, including oral cancer, esophageal and gastric carcinoma, lung cancer, reduced pulmonary function, and decreased fertility. Sharing a hookah may increase the risk of transmission of certain infectious diseases, including tuberculosis, viruses such as herpes or hepatitis, and other illnesses.

The language used in state laws regulating smoking in public places determine whether hookah would be covered or not. For example, Delaware law addresses "the burning of a lighted cigarette, cigar, pipe or any other matter or substance that contains tobacco." However, the language in some states could actually exempt hookah bars or cafes. This may be the case in Connecticut where a test case is currently before the Department of Public Health.

Recommendation #10: Encourage adoption of Healthy Home Concept of no smoking policies in homes.

Background: Second-hand smoke (SHS) has a negative impact on the health of children. Almost 60 percent of U.S. children aged 3-11 years are exposed to secondhand smoke. Children exposed to secondhand smoke are at a greatly increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Many children and non-smokers are exposed to SHS because they live with a smoker. In 2008, five percent of non-smokers in Connecticut were exposed to second-hand smoke in their homes.

The latest Surgeon General report found children are the only population group not to have seen significant progress in being protected from secondhand smoke.[19] Secondhand smoke is a carcinogen, for which there is no 'risk-free" level of exposure. Research now indicates exposure to third hand smoke, by definition the toxins, odors, and residues that remain on clothes, furniture and hair long after the cigarette has been extinguished, is extremely dangerous as well. A home is not a healthy home unless it is a smoke free home. While the government regulates several environmental health hazards that may be found in the home, including lead, mold and asbestos, smoking behavior remains unregulated (by the government) in housing. By eliminating smoking in multiunit housing, landlords are eliminating the number one causes of preventable death in the place people, especially children and elderly spend the majority of their time. Equally important, a 2010 report published by the Department of Housing and Urban Development (HUD), notes more than 7 million people live in public housing in the United States, with 4 in 10 units occupied with families with children.[20]

This recommendation focuses on developing voluntary approaches in partnership with owners and residents to reducing secondhand smoke in multi-housing units, condominiums, apartments, assisted living facilities, group homes, public housing and shelters. There is no 'one-sized fits all' approach to policy adoption. It is important that landlords adopt policies that meet the needs of their property and their tenants, whether that is to ban smoking in the indoor of the building, provide designated smoking areas, or ban tobacco use completely from the confines of their property.

While there may be opposition from the general public, policymakers and pushback because of the fear of violating first amendment rights of the smoker, it is important to understand smokefree policies are not designed to be punitive, or prohibit smoking, but are intended to encourage smokers to

smoke in locations outside for the safety of the property and the health of all occupants. In cases where smokefree polices have been adopted throughout the country, it has been shown that "pre-policy" anxiety far outweighs the reality of those concerns as the vast majority of residents want to live in a smokefree environment.

Health and cost benefits: There are several benefits to adoption of such voluntary policies.

- Reduction in the number of families and individuals involuntarily exposed to secondhand smoke
- Reduction in the number of smokers
- Reduction in the number of tobacco smoke-related complaints in multi-housing unit or complex
- Reduction in hospital stays for asthma, bronchitis, respiratory illness in complex
- Reduction in ED visits for asthma, bronchitis, respiratory illness in complex
- Savings to landlords in turnover costs associated with smoking indoors
- Reduction in fire risks associated with smoking materials

Smokefree housing policies are a long term, high complexity issue. However, there are considerable long-term savings in reduced health care and housing costs, improved health outcomes and quality of life. Nationwide, 65-85% of tenants report a desire to live in a smoke-free environment, and landlords can save an average of $3,000 on a turnover unit where smoking is prohibited. Policy adoption is a win-win situation for landlords and tenants; it is the way the message is conveyed that is the most intrinsic for a successful implementation of a smoke-free housing campaign.

On July 17, 2009, the U.S. Department of Housing and Urban Development (HUD) strongly encouraged Public Housing Authorities (PHAs) to implement non-smoking policies in some or all of their public housing units. Attachment A contains a list of the evidence-based policies implemented by the federal government and other states.

Recommendation #11: Require school districts to establish and maintain no tobacco use policies on school grounds and school events (including day-care, K-12 and college /university settings).

Background: There are no uniform policies for schools in Connecticut regarding tobacco use on school grounds and at school events. While all elementary schools have no smoking policies for students within the school, smoking on the grounds varies and may not be well enforced. Many of our colleges and universities allow smoking on the grounds and in dormitories. School and college/university properties are used for many after school and non-education events (e.g., after school care, sports events, etc.). Smoking should be banned at such events.

All Connecticut schools must be committed to providing a healthy environment for their students and staff. Therefore, a minimum standard set of no tobacco use policies need to be implemented that prohibits tobacco use on school grounds at all times and at all school sponsored events on or off school grounds. Schools may also create policies that are stronger than the minimum set.

The Department of Public Health in concert with the State Department of Education will need to draft standardized polices. School employees and school boards may oppose the policy because it involves no tobacco use at all times on school grounds, even after minors have left school for the day. Some expected outcomes of adopting a uniform no tobacco use policy on school grounds include:

A majority of schools across the state will be implementing the standard policies.

C. POLICY/ENVIRONMENT: Update, adopt, implement ,fund and sustain a Comprehensive Tobacco Prevention and Control Plan as recommended by the Centers for Disease Prevention and Control.

Recommendation #12: Update, adopt, implement, fund and sustain the *Connecticut Tobacco Use Prevention and Control Plan*.

- Document the return on investment for sustaining proper funding for tobacco prevention and cessation programs to educate the legislative and executive branch on this issue.
- Require appropriate funds received from MSA and Tax revenue from tobacco sales be applied to a sustainable comprehensive tobacco control

program (CDC currently recommends $43 million annually for such programs).

- Provide sustained funding for anti-tobacco media programming that incorporates evidence-based strategies and current technologies including social marketing.
- Partner with community-based organizations including the faith-based organizations to reach high risk populations.
- Provide sustained funding for anti-tobacco media programming that incorporates evidence-based strategies and current technologies including social marketing.
- Partner with community-based organizations including the faith-based organizations to reach high risk populations.

Background: In 1998 Connecticut was one of 46 states to settle lawsuits against the four major tobacco companies. Under this agreement states will receive annual payments in-perpetuity. In the first twenty-five years alone states will receive $246 billion from the Tobacco Master Settlement with Connecticut's portion $3.6 to $5 billion (approximately $175 million per year). At the time, public health advocates and the Attorneys General expected that a substantial portion of these funds would be used for tobacco prevention and treatment programs. Unfortunately, that has not been the case in most states.

The Centers for Disease Control and Prevention first published *Best Practices for Comprehensive Tobacco Control Programs* in August, 1999, shortly after the historic settlement with the American tobacco industry. An updated edition was released in October, 2007. This comprehensive approach that optimizes synergy through a mix of educational, clinical, economic, regulatory, and social strategies has become the principal standard for eliminating the health and economic burden of tobacco use. Evidence for the effectiveness of comprehensive programs has greatly increased with the growth in state capacity and a focus on proven interventions. CDC recommends five components of a comprehensive tobacco program: State and Community Interventions, Health Communication Interventions, Smoking Cessation, Surveillance and Evaluation and Administration and Management. In their 2007 Best Practices Guidelines, CDC provides state-by-states recommendations for how much funding should be spent for each component for successful outcomes. [1] To that end, an updated comprehensive Tobacco Use and Control Plan is necessary to direct and coordinate state efforts to

prevent initiation, increase cessation and advocate for effective policies and laws. This comprehensive plan should also combine educational, clinical, regulatory, economic, and social strategies.

A comprehensive statewide tobacco control program is a coordinated effort to establish smoke-free policies and social norms, to promote and assist tobacco users to quit, and to prevent initiation of tobacco use. This comprehensive approach combines educational, clinical, regulatory, economic, and social strategies. Research has documented the effectiveness of laws and policies in a comprehensive tobacco control effort to protect the public from secondhand smoke exposure, promote cessation, and prevent initiation, including increasing the unit price of tobacco products and implementing smoking bans through policies, regulations, and laws; providing insurance coverage of tobacco use treatment; and limiting minors' access to tobacco products. Additionally, research has shown greater effectiveness with multi-component intervention efforts that integrate the implementation of programmatic and policy interventions to influence social norms, systems, and networks.[1]

Community-based interventions focus on 1) prevention of initiation among youth and young adults, 2) promoting quitting among adults and youth, 3) eliminating exposure to secondhand smoke, and 4) identifying and eliminating tobacco-related disparities among population groups. Health communication interventions can be powerful tools for promoting and facilitating smoking cessation, preventing smoking initiation and shaping social norms related to tobacco. Traditional health communication and counter-marketing strategies use multifaceted efforts, including paid TV, radio, print, billboard, and web-based advertising, on-line networking, and media. Campaigns as early as 1999 demonstrated the effectiveness of anti-tobacco advertisements to affect smoking attitudes and beliefs.1

CDC compiled "best practices" to help states organize their tobacco control program efforts into an integrated and effective structure. The 2007 guide included state by state recommended funding levels for each program component. These recommended levels of annual investment factor in state-specific variables, such as the overall population; the prevalence of tobacco use; the proportion of the population that is uninsured, receiving publicly financed insurance, or living at or near the poverty level; infrastructure costs; the number of local health units; geographic size; the targeted reach for Quitline services; and the cost and complexity of conducting mass media to reach targeted audiences, such as youth, racial/ethnic minorities, tobacco users interested in quitting, or people of low socioeconomic status.[1]

In Connecticut, CDC recommends an annual spending rate of $12.54 per capita ($43.9 million) for Comprehensive Tobacco Programs. Table 2 lists total funding to date from the Tobacco and Health Fund Trust.

The legislature established the Tobacco and Health Trust Fund (THTF) in 1999 and created a Board of Trustees in 2000. It directed the transfer of $12 million annually from the Tobacco Master Settlement dollars into the THTF to create a continuing, significant source of funds to encourage the development of programs to reduce tobacco abuse, to reduce substance abuse and to meet the unmet physical and mental health needs of the state. Initially, the THTF Board was only authorized to recommend expenditure of the interest earned on the fund principal. In 2008, the legislature amended this authority to allow expenditure of half (up to $6 million) of the previous year's transfer from the Master Settlement to the THTF. Since its inception through FY2011, the THTF will have received $153 million and $114 will have been transferred out.[1] The legislature transferred $81.1 million back into the General Fund and another $38 million to other programs and services. In fact, the THTF Board of Trustees has only been allowed to spend $9.2 million from the fund on tobacco prevention and control programs. The majority of the Trust Board expenditures (74%) were authorized in FY09 and FY10 (Table 2). [3,10] The constant raids on the Trust Fund have left the fund with a balance of just $5.2 million after the FY10 allocations. The current budget calls for additional transfers from the fund and it is likely the fund will be extinguished by the end of the biennium. The THTF dollars spent on tobacco prevention and control represent nearly all of the funds supporting anti-tobacco activities in Connecticut, and collapse of the fund would be a serious blow to anti-tobacco goals. During the 2010 legislative session, the legislature swept the remaining $5 million from the THTF principal balance for mitigation of the FY2010 budget.[3, 10, 21]

Table 2: Tobacco and HealthTrust Fund Board Disbursements FY03 – FY09

Category	*FY03 -FY08*	*FY09*	*FY10*	*Total*
Counter Marketing	$450,000	$2,000,000	$1,650,000	$4,100,000
Website Development	$50,000			$50,000
Cessation Programs (Community-Based)	$1,500,000	$412,456	$750,000	$2,662,456
Cessation for Mentally Ill		$1,200,000	$800,000	$2,000,000
Quit-line	$287,100	$2,000,000	$1,650,000	$3,937,100
School-Based		$500,000	$500,000	$1,000,000
Lung Cancer Pilot		$250,000	$250,000	$500,000
Evaluation		$500,000	$300,000	$800,000
Innovative Programs			$477,745	$477,745
Total	**$2,287,100**	**$6,862,456**	**$6,377,745**	**$15,527,301**

States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs increased. In Florida, between 1998 and 2002, a comprehensive prevention program anchored by an aggressive youth-oriented health communications campaign, reduced smoking rates among middle school students by 50% and among high school students by 35%. Other states, such as Maine, New York, and Washington, have seen 45% to 60% reductions in youth smoking rates with sustained comprehensive statewide programs.[16-18] Between 2000 and 2006, the New York State Tobacco Control Program reported that the prevalence of both adult and youth smoking declined faster in New York than in the United States as a whole.[1] Adult smoking prevalence declined 16% and smoking among high school students declined by 40%, resulting in more than 600,000 fewer smokers in the state over the 7-year intervention period.

According to the American Cancer Society (ACS), even by the most conservative estimates, more than 40% of the reduction in male cancer deaths between 1991 and 2003 was due to the declines in smoking over the last half of the 20th century. Before cigarette smoking became common, lung cancer was a rare disease. Now lung cancer is the leading cancer cause of death for both men and women, killing an estimated 160,000 people in this country each year.20 ACS estimates that approximately 87% of these deaths are caused by smoking and exposure to secondhand smoke. Additionally,

more than 100,000 deaths from lung diseases, and more than 140,000 premature deaths from heart disease and stroke are caused each year by smoking and exposure to secondhand smoke. Research shows that the more states spend on sustained comprehensive tobacco control programs, the greater the reductions in smoking—and the longer states invest in such programs, the greater and faster the impact.[12] In California, home of the longest-running comprehensive program, smoking rates among adults declined from 22.7% in 1988 to 13.3% in 2006. As a result, compared with the rest of the country, heart disease deaths and lung cancer incidence in California have declined at accelerated rates. Among women in California, the rate of lung cancer deaths decreased while it continued to increase in other parts of the country. Overall, from 1987–1998, approximately 11,000 cases of lung cancer were avoided. Since 1998, lung cancer incidence in California has been declining four times faster than in the rest of the nation.[1]

Since FY2000, Connecticut has received about $1.3 billion from the tobacco settlement, but less than two percent of that money has been used for programs aimed at reducing smoking or targeted toward anti-tobacco advertising and other efforts. Instead, 86 percent of the Tobacco Settlement funds ($1.1 billion) have been used for unrestricted spending in the General Fund.[3,10,21] At $3.00 per pack, Connecticut state taxes on cigarettes are among the highest in the nation. For FY 2010, the Campaign for Tobacco Free Kids reported estimated cigarette tax revenues of $377.9 million and master settlement revenue of $141.3 million, with only $7.2 million spent on tobacco prevention and control.

From 2000 through 2009, the state received $1.3 billion in tobacco settlement money and $2.36 billion in cigarette tax revenues, for a total of $3.655 billion. However, they have spent only $18.3 million (6.75%) on tobacco prevention and control.[22] Prudent use of some of these revenues to fund a comprehensive tobacco prevention plan would result a many-fold return on investment in a very short time, and save countless lives and billions of dollars in the long term.

D. POLICY/ENVIRONMENT: ENFORCEMENT

Recommendation #13: Pass tax parity on all other tobacco products and insure any future tobacco tax increases include all tobacco and tobacco-related products.

Background: There is currently no parity between cigarette and loose tobacco products in Connecticut. Taxes on loose tobacco are considerably lower and have not changed in many years. Legislation introduced in the

2010 legislative session (SB 543) would have changed the tobacco products tax on non-cigarette smoking tobacco, including pipe and roll your own tobacco, from 27.5% of the wholesale price to 15 cents (150 mills) per 0.0325 ounces.

Benefits: This would make the non-cigarette tax equal to the tax rate on cigarettes. Approximately 460,000 ounces of roll-you-own and pipe tobacco are sold each year in Connecticut. In addition to reducing the smoking of loose tobacco, this increase would generate approximately $1.3 million per year in addition tobacco tax revenue.

Recommendation #14: Redirect revenues generated through enforcement of youth tobacco access laws under CGS§12-295a(c) and CGS §53-344. (b) for tobacco prevention services concerning merchant and community education and administrative hearings.

- Increase the number of Department of Revenue Services administrative hearing officers to ensure full enforcement of the current laws.
- Mandate merchant education for first time violators that sell tobacco to minors instead of the imposed fine.
- Make merchant education compulsory for second time violators that sell tobacco to minors in addition to the imposed fine and pay for the training.
- Suspend the licenses for tobacco dealers that fail to pay imposed fines under CGS §12-295a(c).
- Require mandatory merchant education <u>before</u> a suspended licenses is activated under CGS §12-295a(c).

<u>Background:</u> Currently, levies collected for criminal infractions and administrative fines go into the general fund. In July 1992, Congress enacted the Synar Amendment as part of the Alcohol and Drug Abuse and Mental Health Administration Reorganization Act (P.L.103-321). The Synar Amendment is aimed at decreasing access to tobacco products among individuals under the age of 18 by requiring states to enact and enforce laws prohibiting any manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18. States are in compliance when the rate of sales to minors occurs at less than 20% of all outlets. The Synar Amendment further defined state requirements for conducting unannounced inspections of a random sample of tobacco vendors, to assess their compliance with the state's access laws and filing an annual

report. Each state must submit an annual report to the Secretary of Health and Human Services describing that year's enforcement activities, the extent to which the state reduced the availability of tobacco to minors, and a strategy including a time frame for achieving and maintaining a retailer violation rate (RVR) of no greater than 20 percent. A state that does not meet its targeted reduction is penalized 1 percent of its federal Substance Abuse Prevention and Treatment (SAPT) block grant funds for each percent it is over the 20 percent minimum threshold. Applying the above referenced recommendations will ensure that tobacco merchants who fail compliance inspections will receive training and education so the State of Connecticut can achieve and maintain a RVR in accordance with prescribed federal mandates.

Due to a lack of administrative hearing officers the Department of Revenue Services (DRS) issued 340 warning letters to first time violators under the CGS §12-295a in FY 2009, instead of imposing an administrative fine of $300. (The Connecticut Annual Synar Report, FFY 2010, Department of Mental Health and Addiction Services.) This represents a loss of $102,000 in possible revenue collections in 2009. In the last five years, following this current protocol, DRS has forfeited well over one half million dollars in possible revenue collections. The fines imposed do not represent the actual fines collected due to the lack of additional administrative action (i.e., license suspension/revocation) against the license holder who failed to pay the fine. The Department of Mental Health & Addiction Services' Summary Report on Underage Sale of Tobacco 2009 indicates that 160 infractions under CGS §53-344a were issued by police agencies through their Police Partnership Program. This represents additional potential revenue collection by Judicial Branch's Centralized Infractions Bureau of $40,000.

To redirect these revenues to support tobacco enforcement activities within DMHAS, Judicial Branch Centralized Infractions Bureau and the Department of Revenue Services would be required to deposit collected criminal and administrative fines into tobacco merchant and community education fund. The Department of Mental Health & Addiction Services in collaboration with the Department of Revenue Service and the Department of Public Health would augment existing merchant and community education services for individuals who are required to pay fines and those who opt for training. Tobacco retailers might oppose this recommendation because it will require them and/or their employees to take time from their stores to attend training. Failure by the license holder to pay a fine or penalty within a reasonable time period would be grounds for immediate suspension of a license to sell tobacco products.

Fully enforcing current laws would increase resources for merchant and community education. More merchants and retail clerks trained on how to prevent tobacco sales to minors would result in reducing youth access to tobacco. Trained merchants and reduced youth access would lower the RVR, which would not jeopardize block grant funding. Enhanced prevention enforcement activities would better position Connecticut for future funding under the Family Smoking Prevention and Tobacco Control Act. This law, passed in 2009, gave the Food and Drug Administration authority over tobacco products and advertising.

Recommendation #15: Provide voluntary cessation services for youth who are fined under the §53-344.(c) for possession of tobacco.

Background: Approximately 48,600 middle and high school students in Connecticut used some form of tobacco on at least 1 of the 30 days prior according to the Department of Health's 2007 School Health Survey. In October 2008 the youth tobacco possession law came into effect, and according to the Judicial Branch 246 youth were ticketed under this law in 2009. Minors are issued a $50.00 fine for a first time offense of possessing tobacco products and up to $100.00 for each subsequent offense within 18 months. The statute fails to address or provide a tobacco use cessation option. Currently, there are no requirements to provide cessation services to youth who are tobacco use dependent. Youth fined under this law should receive information about cessation services so they can easily access resources to quit using tobacco products. This preventative measure will reduce the number of youth that could develop tobacco dependency as adults by increasing cessation opportunities. Providing cessation services for youth with tobacco dependencies will ultimately reduce the health care costs associated with the treatment of tobacco related illnesses.

The data received from the Judicial Branch does not indicate previous violators or the final disposition/outcome of the cases. Assuming all tickets were issued to first time violators, potentially $12,300 went into Connecticut General Fund as a result of enforcement of this law during the 2009 calendar year.

Operationalizing this recommendation would require infractions information be shared with the Department of Public Health, who in coordination with the Department of Mental Health and Addiction Services and State Department of Education would develop a process for referring these youth violators to school or community tobacco cessation programs. Municipal Police agencies may oppose this recommendation as they may consider it a burden on current work demands. Expected outcomes include an increase in the number of: youth

who access cessation services; an increase in quit attempts by youth who participate in cessation programs will increase; and an increase in community resources available to youth in preventing tobacco addition will also increase.

Current cessation programs need to build their capacity on how to provide cessation services to meet the needs of youth tobacco users. School resource officers, community social service providers, youth services agencies, along with prevention and health care professionals will need training on youth targeted cessation services. The Department of Public Health and the Department of Mental Health and Addiction Services will be instrumental in implementation of this type of targeted training. These services are expected to be of a long term, low complexity nature that will utilize preexisting agencies and best practices tobacco cessation programs for minors.

E. POLICY/ENVIRONMENT: RETAIL SALES

Recommendation #16: Urge the FDA to expand access to over the counter (OTC) nicotine reduction therapies (NRT) and support similar initiatives in other states.

Background: In order to expand access to nicotine reduction products (NRTs) a suggestion of the Tobacco Task Force is to allow non prescription NRTs to be sold by retailers licensed to sell other OTC medication. It is also suggested that OTC NRTs be made available in smaller pack sizes vs. the two week supply currently available.

In January 2008, Richard Daines, the New York State Commissioner of Health, submitted a citizen's petition to the Secretary of DHHS and the Food and Drug Administration requesting expansion of the availability of nicotine replacement therapy to consumers who use tobacco. In August 2008, the FDA responded that they had not reached a decision in regard to this issue. It is time to pursue a decision in this matter.

The current restrictions on selling non prescription NRTs and the pack size are based on FDA requirements.

Health Benefits

Broader access to NRTs in local shopping settings.

No Economic Burden is foreseen.

Any pack size change is the cost of the manufacturer of the product

Recommendation

The Task Force recommends that state officials, such as the AGs office, send letters urging the FDA to take up this topic and expand access to OTC NRTs.

Recommendation #17: Prevent youth access to tobacco products by restricting new cigarette licenses and reducing current cigarette license renewals

- Eliminate all vending machines by April 2011
- Eliminate renewals and new licenses to all Bars and Restaurants by October 2011
- Eliminate renewals and new licenses to all Drug Stores by January 2012
- Eliminate Mass Merchants and Supermarkets / Grocery Stores over 3000 square feet by July 2012
- Determine if there are any other locations that have licenses that are deemed inappropriate.

Background: Controlling youth access to tobacco products is an important aspect of reducing youth tobacco use. DMHAS is charged with the responsibility of monitoring licensed tobacco merchants to ensure they are enforcing limitations on youth access. There are currently 3 inspectors for over 4000 licensees. On average, a licensee will have a compliance check at least every 18 months with those that have failed previous compliance checks receiving them more frequently.

The 2009 SYNAR report indicated that less than 10% of Connecticut tobacco merchants failed compliance checks. These are great numbers that need to be maintained or improved to ensure continued federal block grant funding from SAMHSA for a range of prevention and treatment programs.

To ensure that annual inspections are conducted, the number of licensees should be reduced. Family oriented merchants and food establishments would be phased out over time. For example, the City of Boston no longer allows drug stores to hold tobacco merchant licenses.

As of March 4, 2010 there were 4,239 recorded licensed tobacco merchants. This information is updated on the 25th of each month by the keeper of the records which is the tobacco licensing agency in the Department of Revenue Services.

The licensees are not sorted by type of establishment on the web site. As of March 4, 2010, DMHAS had identified 90 vending machine locations and 4,149 over the counter locations. Licensed tobacco merchants in the state include:

- 180 chain supermarkets
- 80 independent supermarkets over 3000 sq ft
- 300 chain drug stores
- 25 independent drug stores
- 32 large "big box" retailers
- 90 vending machine locations, many of these are in bars, cafes, deli's pizzerias, golf courses, auto repair / cleaning sites
- 25 check cashing sites – possibly vending sites
- several low price variety stores

Table 3 indicates current license fee revenue and estimates of changes if renewal fees are increased and if the number of licenses is reduced:

Table 3: Estimated Effects of Changes Tobacco Merchant License Volume and Renewal Fees

	Jul-10	*Jul-12*	*Oct-11*	*Jul-12*
Policy Change	Current	Current fee; fewer licenses	Increased fee; fewer licenses	Increased fee; fewer licenses
Total Licenses	4,239	3,132	3,749	3,132
License Renewal Fee	$50	$50	$75	$100
Total Revenue	**$211,950**	**$156,600**	**$281,175**	**$313,200**
Change +/(-)		($55,350)	$69,225	$101,250

Economic Impact: Neutral to slight gain in revenue. As proposed there will be a slight revenue gain of $101,500 once fully implemented by July 2012. This does not call for any "grandfathering" under current law.

Recognizing the concerns from all retail sectors about lost income source and concerns over more regulations, the following recommendation is offered to address those issues to ensure that the retail sector remains competitive and vital in the state of Connecticut.

Recommendation #18: Support the Connecticut Fair Trade Law which helps counteract manufacturer trade discounting and encourage an increase to keep a viable and competitive retail economic sector to Connecticut's economy.

Background: Cigarette price increases reduce the demand for cigarettes and thereby reduce smoking prevalence, cigarette consumption and youth initiation of smoking. Fair Trade laws were established by states in the 1940's to protect tobacco retailers from predatory business practices. The laws require adding a minimum percentage markup to the manufacturer's list price at the wholesale level and again at the retail level.

Cigarettes rank as the largest category by share of sales in convenience stores, contributing on average 32.9% of inside dollars in 2008 as stated in the NACS SOI report. Cigarettes are the third contributor to gross margin dollars / profits for convenience stores. OTP (other tobacco products) contributed 11.9% to inside sales making it the sixth highest sales category.

Economic Burden: In Connecticut, both the wholesaler and retailers are struggling with profitability as the consumption of cigarettes continues to decline. The cost of doing business in Connecticut is considerable and the loss of revenue in this area is causing higher costs/retails on non tobacco products to make up for the losses. The Task Force supports an increase to both the wholesaler and retailer minimum markups (amounts to be determined).

Massachusetts, recognizing that the retailer was the front line in preventing youth access sales, opted to increase their minimum markup over 10 years ago to help the retailer make up for lost revenue.

Health Benefits: Further reduction in demand and a higher threshold to prevent young smokers from starting.

Cost: This increase would reduce the excise tax collection on cigarettes. There would be a slight increase in sales tax collected. All depends on the percentages established. Today, the state of Connecticut has an excise sales tax of $30.00 per carton. The retailer lags behind this making approximately $8-$9 per carton – this profit on reduced demand is not allowing retailers to cover increases in medical benefits, electricity, minimum wages. The wholesaler is in the same boat with limited resources and opportunities to improve themselves and their employee's situations.

Recommendation #19: Ensure a healthy retail environment with ample competition for Connecticut citizens by offering replacement products for lost tobacco revenue for retailers.

Regulations continue to prevent retailers from expanding / replacing tobacco revenue with other viable product lines. 0

Recommendation #20: Strive to optimize FDA funding for collaboration around enforcement of youth tobacco laws

Maine and Massachusetts have received FDA funding to develop preliminary enforcement mechanisms which will be used as models for other states' efforts.

June 22, 2010 marked the first anniversary of the U.S. Food and Drug Administration's (FDA) authority over tobacco under The Family Smoking Prevention Control Act, June 22 was also the date when the agency's tobacco regulations went into effect, including a ban on the words "light" and "mild" when referring to cigarettes.

During the past year, the FDA has:

- Established the Center for Tobacco Products
- Established the tobacco user fee program, which provides funding for FDA tobacco regulation support activities
- Begun to enforce the Act's prohibition on manufacturing, distributing or selling certain flavored cigarettes, such as spice-, fruit-, and candy-flavored cigarettes
- Implemented new statutory authorities, under which tobacco product manufactures have registered their establishments and listed their products with the FDA, provided detailed information about product ingredients and their own research into the health effects of their products
- Convened a Tobacco Products Scientific Advisory Committee, which began to study the impact of the use of menthol in cigarettes on the public health

The following provisions of the Act become effective on June 22, 2010:

FDA rules that limit the sale, distribution, and marketing of cigarettes and smokeless tobacco to protect the health of children and adolescents become legally enforceable

Provisions that prohibit the advertising or labeling of tobacco products with the descriptors "light," "mild," or "low" or similar descriptors without an FDA order

Requirements that new, larger health warning labels for smokeless tobacco products begin to rotate on labels, labeling, and advertising and begin to be displayed on smokeless tobacco packaging [23]

F. POLICY/ENFORCEMENT: Surveillance

Recommendation #21: Develop a surveillance mechanism that utilizes health information developed through statewide health information exchanges and Sustinet.

- Collect and analyze data related to smoking prevalence, cessation interventions and quit rates and other parameters necessary to evaluate the utilization, efficacy and cost-effectiveness of tobacco prevention and control strategies.

- Launch a comprehensive, time-sensitive Information Technology (IT) system linking patient, medical encounter, smoking prevalence and tobacco-related morbidity.

- Maintain ongoing surveillance of targeted groups to assess effectiveness of tobacco prevention and control strategies.

- Engage health prevention experts and public health epidemiologists in development of the variables for inclusion in the electronic record to maximize its value to provide not only appropriate individual patient care, but also to use as population based surveillance tools to measure prevalence of risk factors and behaviors that contribute to and mediate disease, utilization of prevention services, including tobacco use cessation, and evaluation of their costs (and savings) as well as their efficacy.

Background: Sustinet expects to participate in developing a system for electronic health records. This will be an extensive and expensive process, as anyone who has developed major data systems is aware. Dr. Robert Aseltine, a member of the IT Advisory Committee, is currently the principal investigator for the Connecticut Health Information Network (CHIN), which would enable research with data combined across Connecticut state agencies that was previously impossible. Researchers and public health officials share an understanding of the need for health data bases that go beyond the concept of merely the standard medical record.

As part of the Health Care Reform legislation, the federal government will also be requiring information on Preventative Services and client risk factors that contribute to and mediate chronic diseases. On June 18, 2010, Secretary Sibelius announced the Prevention and Public Health Fund created by the Affordable Care Act. Included in the latest round of $250 million is $122 million for Community and Clinical Prevention. These funds will support federal, state and community prevention initiatives; the integration of primary

care services into publically funded community-based behavioral health settings; obesity prevention and fitness; and tobacco cessation.

This new interest in prevention and wellness, along with secondary and tertiary care of the individual as "patient", requires a new way of organizing information on the clients we serve in the health care setting. It is interesting that although we refer to our system of care as "health care", it has traditionally focused only on "disease care". The cost of this downstream focus has forced those who pay for this care to move the focus upstream and begin to focus on those behavioral and environmental factors that can be modified to prevent or ameliorate the disease. This focus not only saves lives, but is also more cost effective. Whatever IT system is finally developed needs to be a merger of the two approaches to increase the health of the people; preventing disease and treating it when it does occur. Additionally, it must be developed to be useful for the individual client and for population based research and surveillance that can provide long-term trend analysis to measure outcomes and costs.

A comprehensive tobacco surveillance system will provide disease control specialists and legislators necessary information about the utilization and impact of tobacco on populations, as well as the capacity to monitor tobacco industry practices.[24] The World Health Organizations (WHO), in cooperation with the U.S. Centers for Disease Control and Prevention (CDC) other stakeholders have long advocated for implementation of a Global Tobacco Surveillance System (GTSS).

This comprehensive toolkit consists of four validated and effective population survey instruments to assess tobacco use and impact that can provide national and international comparative data to assess progress reaching specific tobacco control targets.

Youth Tobacco Survey (YTS): The YTS focuses on youth aged 13-15 and collects information in schools. The YTS is a 56 item questionnaire for gathering data on individual's awareness and knowledge about smoking and environmental tobacco smoking (ETS), prevalence of tobacco use, the impact of media and advertising on youth attitudes about tobacco, youth access to tobacco products, their exposure to tobacco control curriculum in schools and the awareness and experience of young smokers about cessation opportunities.

The School Personnel Survey (SPS) The SPS surveys teachers and administrators from the same schools that participate in the YTS regarding tobacco use, their knowledge and attitudes about tobacco, availability and

student access to resources focused on the prevention and control of tobacco use by students and the , existence and effectiveness of tobacco control policies in schools.

The Health Professions Student Survey (HPSS) The HPSS is intended for advanced (e.g., 3rd year) students enrolled in Dental, Medical, Nursing and Pharmacy programs about their use of tobacco, knowledge and attitudes about smoking and environmental tobacco smoke, training received on counseling patients to stop smoking and willingness of smokers to stop.

Adult Tobacco Survey (ATS) The ATS is a household survey of adults to monitor prevalence of cigarettes and smokeless tobacco products, exposure to environmental tobacco smoke, knowledge, attitudes and perceptions about tobacco, impact of media on knowledge and perceptions of tobacco, economics of smoking and efforts by smokers to stop.

Surveillance of tobacco industry efforts to undermine tobacco control efforts is equally important. Recognizing new marketing strategies and roll out of new devices for delivery for tobacco use are critical in developing effective counter marketing and regulatory strategies.

Reference documents

1. Centers for Disease Control and Prevention, *Best Practices for Comprehensive Tobacco Control Programs –2007*. Atlanta: U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007. Available at: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

2. Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: U. S. Department of Health and Human Services. Public Health Service. May 2008. Available at: http://www.surgeongeneral.gov/tobacco/

3. The Connecticut Public Health Policy Institute. Cooney, J; Cohen, J; Checko, P; et.al. Examining Tobacco Use, Consequences and Policies in Connecticut: Smoke and Mirrors? University of Hartford: April 28, 2010 http://enhp.hartford.edu/ctphp/pdf/Tobacco_Issue_Brief_Final.pdf

4. Massachusetts Department of Public Health: Massachusetts Tobacco Control and Prevention Program. Annual Report, Fiscal Year 2009. http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/annual_report_2009.pdf

5. Healthy People 2020 Proposed Objectives for Tobacco Use. http://healthypeople.gov/HP2020/Objectives/TopicArea.aspx?id=47&TopicArea=Tobacco+Use

6. Centers for Disease Control and Prevention. *Tobacco Control State Highlights 2010*. Atlanta:

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2010.

7. Centers for Disease Control and Prevention (CDC). *Behavior Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2009].

8. Connecticut School Health Survey, 2009 and 2007. http://www.ct.gov/dph/lib/dph/hems/tobacco/pdf/2009_youth_smoking_pdf.pdf

http://www.ct.gov/dph/lib/dph/hems/tobacco/pdf/cshs_2007_report.pdf

9. Connecticut Department of Public Health. *Connecticut Tobacco Use Prevention and Control Plan, 2002*. Hartford, CT: Connecticut Department of Public Health. 2002.

10. Tobacco and Health Trust Fund Board of Trustees: Fiscal Year 2010 Report to the Appropriations and Public Health Committees ND THE Connecticut General Assembly. December 2009. Available at http://www.ct.gov/opm/lib/opm/secretary/tobacco/tobacco_report_fy_2010.pdf

11. Connecticut Voices of Children. Smoking Cessation Treatment needed for HUSKY Members; February 2008. http://www.ctkidslink.org/publications/h08smokingcessation.pdf

12. Massachusetts Department of Public Health, *Study shows dramatic effect of cessation benefit*. 2009. Available at http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/cessation_benefit_study.pdf

13. The American Legacy Foundation. 2007. *Saving Lives, Saving Money: Why States Should Invest in a Tobacco-Free Future II.* Available at http://www.legacyforhealth.org/PDFPublications/saving_lives_saving_money.pdf

14. Berman, M; Crane, R. *Mandating a Tobacco-free Workforce: A Convergence of Business and Public Health Interests.* Tobacco Control Legal Consortium. Going Too Far? Exploring the Limits of Smoking Regulation. William Mitchell Law Review: Symposium Proceedings: Vol. 34; No.4, 2008

http://www.publichealthlawcenter.org/sites/default/files/resources/tclc-symposium-law-review.pdf

15 National Tobacco Cessation Collaborative

16. Personal Communication. Geralyn Laut, Certified Tobacco Treatment Specialist.

17. Center for Prevention and Health Services. Issue Brief: Reducing the Burden of Smoking on Employee Health and Productivity. Volume 1, Number 5. Washington, DC: National Business Group on Health, at: http://www.acsworkplacesolutions.com/documents/WBGHIssueBriefonSmokingCessation.pdf

18. Halpern MT, Dirani R, Schmier JK. Impacts of a smoking cessation benefit among employed populations. *J Occup Environ Med.* 2007;49:11-21.

19. Office of the Surgeon General. The heath consequences of involuntary tobacco smoke: a report of the Surgeon General. Washington, DC: Department of Health and Human Services 2006.

http://www.surgeongeneral.gov/library/secondhandsmoke/secondhandsmoke.pdf

20. Smoke-Free Environments Law Project. Regulation of Smoking in Public Housing, New England Journal of Medicine 362;24. NEJM June 17, 2010.

21. Tragakiss,T. Connecticut's Tobacco Windfall: A Billion Dollars Up in Smoke. July 2009. Yankee Institute for Public Policy, Inc. Available at *www.yankeeinstitute.org/wp-content/ TobaccoStudy.pdf*

22. Campaign for Tobacco Free Kids; Tobacco Revenues by State.

http://www.tobaccofreekids.org/research/factsheets/pdf/0178.pdf

23. Status of FDA Regulations. http://www.fda.gov/TobaccoProducts/NewsEvents/ucm216493.htm

24. World Health Organization, *Tobacco Industry Interference with Tobacco Control*, Geneva, 2008.

Referenced and Recommend Attachments

Connecticut School Health Survey 2007

CT Judicial Branch 2009 Court Statistical Data, Centralized Infractions Bureau

List of known cessation programs: www.ct.gov/dph/lib/dph/hems/tobacco/pdf/tobacco_use_cessation_programs_in_connecticut_2010.pdf

Centers for Disease Control and Prevention

State Cigarette Minimum Price Laws – US 2009

MMWR weekly report April 9, 2010 / 59 (13); 389-392

NACS State of the Industry Report for 2008

APPENDICES

The following documents are available at the links below and are contained in a separate compressed file titled "Sustinet Tobacco Use Cessation Task Force Report Appendices."

Appendix 1:

The Connecticut Public Health Policy Institute. Cooney, J; Cohen, J; Checko, P; et.al. **Examining Tobacco Use, Consequences and Policies in Connecticut: Smoke and Mirrors?** University of Hartford: April 28, 2010 http://enhp.hartford.edu/ctphp/pdf/Tobacco_Issue_Brief_Final.pdf

Appendix 2:

Massachusetts Department of Public Health: Massachusetts Tobacco Control and Prevention Program. **Annual Report, Fiscal Year 2009**. http://www.mass.gov/Eeohhs2/docs/dph/tobacco_control/annual_report_2009.pdf

Appendix 3:

Tobacco and Health Trust Fund Board of Trustees: **Fiscal Year 2010 Report to the Appropriations and Public Health Committees and the Connecticut General Assembly**. December 2009.

http://www.ct.gov/opm/lib/opm/secretary/tobacco/tobacco_report_fy_2010.pdf

Appendix 4:

Tragakiss,T. **Connecticut's Tobacco Windfall: A Billion Dollars Up in Smoke.** July 2009. Yankee Institute for Public Policy, Inc. Available at *www.yankeeinstitute.org/wp-content/ TobaccoStudy.pdf*

Appendix 5:

Healthy People 2020 Proposed Objectives for Tobacco Use. http://healthypeople.gov/HP2020/Objectives/TopicArea.aspx?id=47&TopicArea=Tobacco+Use

Attachment A

Smoke Free Housing Programs

United States (Nationally): Americans for Nonsmokers' Rights: In Your Home:
http://www.no-smoke.org/goingsmokefree.php?id=101

California: Smoke-Free Apartment House Registry:
http://www.smokefreeapartments.org

Colorado: My Smoke-Free Housing: http://www.mysmokefreehousing.com

Maine: Smoke-Free Housing: http://www.smokefreeforme.org

Michigan: MI Smoke-Free Apartment:
http://www.mismokefreeapartment.org

Minnesota: Live Smoke Free: http://www.mnsmokefreehousing.org

Minnesota: Minnesota Multi-Housing Association: http://www.mmha.org

Minnesota: Minnesota Chapter of the National Association for Housing and Redevelopment Officials: http://www.mnnahro.org

Ohio: Smoke-Free Housing: http://www.ohiosmokefreehousing.com

Oregon: Smoke-Free Housing Project:
http://www.smokefreeoregon.com/housing

Utah: The TRUTH: http://www.tobaccofreeutah.org/aptcondoguide.html